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ABSTRACT

The paper examines the goals and effects of early intervention with infants at risk for possible developmental problems. Four components of San Francisco Infant Program are noted: (1) services to children, (2) parent involvement, (3) a transdisciplinary team approach, and (4) a research-based model. The research problems associated with examination intervention's effectiveness are considered, including ethical considerations and restricted measures of program effectiveness (i.e., child change). The author suggests that additional indices, such as the effects on family and community, should be explored as well. (CL)

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Early Intervention Today: A Program Example

Keynote Address

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Miles is a 2 1/2 year old. Born at 29 weeks gentational age, and weighing two pounds, Miles' chances of survival were uncertain. More uncertain was his future development given the complications surrounding his birth. Today at 2 1/2 years Miles can walk and talk and is learning to toilet independently. In short, he closely resembles his playmates and his parents are seeking a preschool program for him in an integrated setting with normal peers. Though intellectual tests on Miles reveal normal cognitive development, Miles has significant motor and speech developmental delays. The road from his birth to a preschool program has been an arduous and joyful one for his parents. Consider his mother's description of the events after his birth.

> Like every expectant parent I had a mental image of what our child would look like and who he or she would resemble most. "He" (I had already decided it was a boy!) would be a chubby healthy baby and the envy of all the new parents on the maternity ward. As it happened, I couldn't have been further from the truth.
>
> When Miles made his appearance nearly three months premature and weighing only two pounds, I cried at my first glimpse of him. He was so incredibly tiny and so pathetic. I was reminded of the detailed pictures of a developing fetus in Nilsson's famous book, "A Child is Born". His head was the size of an orange and his skin was transparent. He was covered with a downy hair, "lanugo", which usually disappears in the last few weeks of pregnancy. His movements were jerky and disjointed, and he seemed confused and upset by his new surroundings.
>
> I was filled with emotion. One moment I'd want to gather him up in my arms and reassure him that everything would be fine and the next moment I was afraid to touch him or get too close to him for fear he'd die and I wouldn't be able to cope.
>
> When I left the hospital a few days later, I was no longer pregnant yet I had no baby to carry home with me. At times it seemed like I had imagined Miles's birth. I felt empty and sad. Each day that I visited Miles I never knew what to expect. I often wondered if he'd still be there when I arrived.

Since Miles' lungs were not fully developed at birth, he needed a respirator to help him breathe. With the respirator and a multitude of other paraphernalia attached to his fragile body, I was unable to hold him. I tried to compensate for this by stroking his thin little body and talking to him. I remember distinctly asking a nuse, "Do you think he hears me talking to him?" And over and over again I would ask, "Do you think he knows who I am?"

As the chances of Miles' survival increased with each passing day, so did my confidence at mothering him. I would stand for hours at the side of his incubator reaching through the portholes and massaging him. I would always begin by rubbing his temples and saying, "Miles, it's your Ma Ma here." I became convinced that he would come to know me through my touch.

To help insure a healthy weight gain for Miles I rented an electric breast pump and faithfully used it every few hours. My milk was given to Miles through a tube inserted in his mouth and leading directly to his stomach. It gave me a deep sense of satisfaction to see him grow and thrive on my breastmilk. I knew it was something I alone could give him and it helped reassure me that I was important to Miles.

Three weeks after his birth, when Miles was no longer on the respirator I held him for the first time. He was bundled up tightly and wore a stocking cap. I kissed his tiny face and put my cheek against his. I wanted so much to take him home.

Seven weeks later when Miles finally did go home I was both extremely happy and frightened. I had come to rely on the hospital for Miles' care and now, suddenly, I would be his primary caregiver. To my relief, the transition from part-time mom to full-time mom was much smoother than I had envisioned, and Miles and I couldn't have been happier.

Kathy Reed
Parent

(Hanson, 1983)

This description of Miles raises many issues with respect to early intervention. I would like to discuss two of these issues with you today:

1) the goals of early intervention;

2) the effects of early intervention.

Intervention Goals

Let me begin with the topic of goals. A major goal of all educational or therapeutic interventions is to facilitate the child's development. In early intervention this may mean teaching the child new skills or preventing a condition from becoming more severe. Since most of us are professionally linked to education, these goals represent common practice in the field, albeit not necessarily with infants. To this important goal of facilitating the child's development, let me add a second -- the goal of supporting early positive parent-infant interaction. In our quest to "treat" the child we have often failed to consider this crucial issue. Failure in this area may actually undermine our attempts to help the child. If we return to the case of Kathy and Miles we witness a very fragile beginning -- a child born too early and unable to interact with his mother, a mother's expectations of the baby she would deliver violated. Yet it is evident from observing Miles and Kathy today that a healthy attachment exists between the two. The great developmental strides made by Miles can be attributed largely to the effort of his mother and father. In this case even though the infant was born at significant risk, a supportive and nurturing family ensured a positive developmental outcome. The child at risk born into a family which fails to support early development is at double jeopardy for achieving a positive outcome. Likewise the child born without risk but living in an at-risk situation may or may not develop optimally. Envision four possible beginning scenarios for any child:

1) the at risk child in a nurturing enviornment
2) the at risk child in an at risk environment

3) the typical child in an at risk environment

4) the typical child in a nurturing environment.

It is evident that at least three of these children may be at significant risk for developmental problems.

Early intervention programs for disadvantaged children have been aimed at the third group listed and have shown great promise at preventing developmental delays. However, this early intervention approach must be expanded to include other types of parental or family risk, such as mental illness, to ensure that these babies too develop optimally.

The major concern for most of us in special education is the at risk or atypical infant; this infant may or may not be raised in a supportive environment. Only through active intervention and support of positive parent-infant interaction can we hope to effectively achieve optimal results with these babies. Programs geared toward this population of children have been available for over a decade on an experimental or limited basis. However, the results of these programs and needs expressed by parents have contributed to their expansion around the country.

An example of one such program is our San Francisco Infant Program.

Let me briefly describe this program's components which include:

1) services to children;

2) parent involvement;

3) a transdisciplinary team approach;

4) a research-based model.

<u>San Francisco Infant Program</u>

NOTE: This program description is provided in the journal article appended to this paper:

Hanson, M.J. A model for early intervention with culturally diverse single and multiparent families. Topics in Early Childhood Special Education, 1981, 1, (3), 37-44.

Intervention Effectiveness

The second major issue I would like to discuss today is that of early intervention effectiveness. For years a debate has raged in various professional circles over whether or not early intervention for at risk and disabled infants "makes a difference". This debate is likely to continue given the scarcity of resources to support health and social services. At the center of this debate is a handful of studies, most of which provide evidence supporting the provision of early services. However, the experimental rigor of many of these studies has been questioned. Scientific inquiry in the medical and social sciences typically demands the use of experimental designs which compare an experimental or "treated" group with a group which does not receive the treatment. Due to ethical and practical considerations most intervention studies cannot employ this type of research design. Therefore, the research in this area often has focused on comparing experimental subjects' gains to typical developmental expectations for the group in question or to some predetermined rate of development. Further, this work almost exclusively has centered on testing for main effects -- the effects on the children's development -- utilizing standardized developmental scales such as the Bayley Scales of Infant Development. With the use of these methods, positive program effects have been demonstrated. However, if we continue to confine our examination of early intervention effectiveness to child change only as measure by these

tests I think we are "barking up the wrong tree." First, developmental scales are not necessarily appropriate instruments for evaluating program effects. Most were not developed for this purpose and insufficiently tap the treament effects. An item, for example, may test for whether or not a child walks but may fail to consider how well, how long or under what conditions the child walks. Further, the potential broader range of treatment effects -- the effects on the family and community and the child's interactions within those units -- are not considered. The effects albeit difficult to systematically measure may be tremendous. Take the case of the child with Down's syndrome. In the past these children typically were institutionalized or at best labeled as trainable. Today most children with Down's syndrome receive early intervention and most go on to learn skills and participate in programs for mildly disabled youngsters. Down's syndrome did not change but our expectations and methods of treating these children did largely as an outcome of our educational successes.

The challenge before us now is not to argue whether early intervention is or is not effective (much like the nature-nurture debate) but to determine the broad range of effects and identify those models which are most effective in assisting children and their families. That challenge does not end until this information is translated at the policy making level to the identification of quality standards for programs and the assurance of a range and continuum of adequate services for disabled and at risk infants and their families.

References

Hanson, M.J. Atypical infant development. Baltimore: University Park Press, 1983